

## CHAPTER 5-000 CHIROPRACTIC SERVICES

5-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), chiropractors must be licensed by the Nebraska Department of Health and Human Services. If chiropractic services are provided outside Nebraska, the chiropractor must be licensed in that state.

5-001.01 Provider Agreement: Chiropractic providers shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in NMAP.

5-002 Covered Services: NMAP limits coverage of chiropractic services to treatment of the spine by manual manipulation (i.e., by use of hands only) and certain spinal x-rays.

5-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

5-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

5-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. Services provided by a chiropractor do not require referral from the client's PCCM primary care physician (PCP). All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

5-003 Non-Covered Services: Except for treatment of the spine by manual manipulation and spinal x-rays, NMAP does not cover any other diagnostic or therapeutic service or supply provided by a chiropractor or on his/her order including, but not limited to:

1. Laboratory tests;
2. Orthopedic devices;
3. Physiotherapy (i.e., ultrasound, diathermy, etc.);
4. Nutritional supplements;
5. EKGs; and
6. Acupuncture.

5-004 Limitations and Requirements for Certain Services

5-004.01 Necessity for Treatment: Manual manipulation of the spine is covered only for the treatment of spinal subluxations for which treatment provides a direct therapeutic benefit.

The chiropractor shall list the following information on the claim when billing NMAP:

1. The diagnosis which includes the level of subluxation; and
2. The symptom(s) that directly relates to the diagnosis (subluxation).

5-004.02 Initial Visit: An initial visit is defined as history, examination, and manual manipulation for a client who has not received services from the chiropractor within the past three years.

5-004.03 Treatment Limitations: The following guidelines outline the maximum number of treatments NMAP may consider for payment:

1. For clients age 21 and older: Manual manipulation of the spine is limited to 12 treatments per calendar year.
2. For clients age 20 and younger: Manual manipulation of the spine is limited to 18 treatments during the initial five-month period from the date of initiation of treatment for the reported diagnosis. A maximum of one treatment per month is covered thereafter if needed for stabilization care.
3. No more than one treatment per client per day is covered.

The chiropractor shall include the following information on or with the claim when billing for manual manipulation:

1. The initial date of treatment billed to NMAP for the reported diagnosis; and
2. The treatment number (e.g., second, fifth, tenth treatment) of manual manipulation billed to NMAP.

5-004.04 Spinal X-Rays: Coverage of spinal x-rays is limited to one anteroposterior and one lateral view of the entire spine or each of the following: thoracic, cervical, and lumbosacral for a client in a twelve-month period.

For spinal x-rays to be covered under NMAP, one or more of the following criteria must be met:

1. Recent acute or violent trauma where there may be a question concerning avulsion, fracture, or subluxation;
2. Chronic or long-standing ailments that have been treated by other practitioners without success and, if x-rays were already taken, they are not available;
3. When there is a pathology or malignancy previously diagnosed, as a precaution to determine if there is any metastasis or in the presence of any osteolytic changes;
4. If there is any indication of existing pathology in the evaluation of the client, the treatment of which may cause additional discomfort;
5. If the client has been under long-term treatment with no alleviation of symptoms; or
6. When specifically required by the Department's utilization review and for documentation of diagnosis and claims for services.

5-004.05 Mileage: NMAP may reimburse a chiropractor for one way mileage for home, nursing facility, and ICF/MR visits beyond a radius of ten miles from the point of origin (office or home). NMAP allows only one mileage charge per day for visits to a nursing facility or ICF/MR regardless of the number of clients treated. When billing NMAP, the chiropractor shall indicate the point of origin, the place where services were rendered, and the total number of miles traveled beyond ten miles from the point of origin or with the claim.

5-004.06 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

5-005 Payment for Chiropractic Services: The Nebraska Medical Assistance Program (NMAP) pays for covered chiropractic services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

5-005.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

5-005.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.

5-005.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008 ff.

5-006 Billing Requirements: Chiropractors shall bill the Department on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

The provider or the physician's authorized agent shall submit the provider's usual and customary charge for each procedure code listed on the claim.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-505).